NEW YORK STATE DEPARTMENT OF HEALTH
Office of Managed Care
Bureau of Managed Care Certification and Surveillance

Utilization Review Agent Registration Application Summary/Checklist

A. Utilization Review Agent Applicant:			DOH/Office of Managed Care/Use Only Reviewer:		
DOH USE ONLY-Date received	Date completed	Incomplete/Noncompliant	Problem letter sent	Complete/Compliant	Registration sent

B. Please Note: Each utilization review agent registering with DOH must report, in a DOH affirmation statement subscribed and affirmed as true under penalties of perjury, the following information: **ATTESTATION STATEMENT ENCLOSED (DOH-4291A)? ☐ YES ☐ NO**

C. EACH POINT IN THE FOLLOWING CHECKLIST MUST BE ADDRESSED. FAILURE TO DO SO WILL RESULT IN THIS APPLICATION NOT BEING PROCESSED IN A TIMELY MANNER

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
§ 4901. Registration of Utilization Review Agents 2. Such report shall contain a description of the following:				
(a) The Utilization review plan;				
(b) Those circumstances, if any, under which utilization review may be delegated to a utilization review program conducted by a facility licensed by Article 28 of the Public Health Law or Article 31 of the Mental Hygiene Law;				
(c) The provision by which an enrollee, the enrollee's designee, or a health care provider may seek reconsideration of, or appeal from, adverse determinations by the utilization review agent, in accordance with the provisions of this title, including provisions to ensure a timely appeal and that an enrollee, the enrollee's designee, and in the case of the case of an adverse determination involving a retrospective determination, the enrollee's health care provider, is informed of their right to appeal adverse determinations;				
(d) Procedures by which a decision on a request for services requiring pre-authorization shall comply with time frames;				
(e) A description of an emergency care policy, which shall include the procedures under which an emergency admission shall be made or emergency treatment shall be given;				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
(f) A description of the personnel utilized to conduct utilization review including a description of circumstances under which utilization review may be conducted by:				
(i) Administrative personnel;				
(ii) Health care professionals who are not clinical peer reviewers; and				
(iii) Clinical peer reviewers;				
(g) A description of the mechanisms employed to assure that administrative personnel are trained in the principles and procedures of intake screening and data collection and are appropriately monitored by a licensed health care professional while performing an administrative review;				
(h) A description of the mechanisms employed to assure that health care professionals conducting utilization review are:				
(i) Appropriately licensed, registered or certified; and				
(ii) Trained in the principles, procedures and standards of such utilization review agents;				
(i) Only a clinical peer reviewer shall render an adverse determination;				
(j) Provision to ensure that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:				
(i) not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not later than the next business day after the date on which the call was received; or				
(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subdivision three of section forty-nine hundred three of this title or an expedited appeal filed pursuant to subdivision two of section forty-nine hundred four of this title, on a twenty-four hour a day, seven day a				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
week basis;				
(k) The policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical and treatment records are followed;				
(l) A copy of the materials to be disclosed to an enrollee or prospective enrollee;				
(m) A description of the mechanisms employed by the utilization review agent to assure that all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent will adhere to the standards and requirements of this title; and				
(n) A list of the payors for which the utilization review agent is performing utilization review in this state.				
§ 4902. Utilization Reviews Program Standards				
1. Each utilization review agent shall adhere to utilization review program standards consistent with the provisions of this title which shall, at a minimum, include:				
(a) Appointment of a medical director, who is a licensed physician; provided, however, that the utilization review agent may appoint a clinical director when the utilization review performed is for a discrete category of health care service and provided further that the clinical director is a licensed health care professional who typically manages the category of service. Responsibilities of the medical director, or, where appropriate, the clinical director, shall include, but not be limited to, the supervision and oversight of the utilization review process;				
(b) Development of written policies and procedures that govern all aspects of the utilization review process and a requirement that a utilization review agent shall maintain and make available to enrollees and health care providers a written description of such procedures including procedures to appeal and adverse determination together with a description, jointly promulgated by the Commissioner and the Superintendent of Insurance and of the external appeal process;				
(c) Utilization of written clinical review criteria developed pursuant to a utilization review plan;				
(d) Establishment of a process for rendering utilization review determinations which shall, at a minimum, include: written procedures to assure that utilization review and determinations are conducted within the timeframes established herein; procedures to notify an enrollee, an				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
enrollee's designee and/or an enrollee's health care provider of adverse determinations; and procedures for appeal of adverse determinations including the establishment of an expedited appeals process for denials of continued inpatient care or where there is imminent or serious threat to the health of the enrollee;				
(e) Establishment of a written procedure to assure that the notice of an adverse determination includes:				
(i) The reasons for the determination including the clinical rationale, if any;				
(ii) Instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred four and an external appeal pursuant to section forty-nine hundred fourteen of this article; and				
(iii) Notice of the availability, upon request of the enrollee or the enrollee's designee, of the clinical review criteria relied upon to make such determination;				
(f) Establishment of a requirement that appropriate personnel of the utilization review agent are reasonably accessible by toll-free telephone:				
(i) Not less than forty hours per week during normal business hours to discuss patient care and allow response to telephone requests, and to ensure that such utilization review agent has a telephone system capable of accepting, recording or providing instruction to incoming telephone calls during other than normal business hours and to ensure response to accepted or recorded messages not less than one business day after the date on which the call was received; or				
(ii) Notwithstanding the provisions of subparagraph (i) of this paragraph, not less than forty hours per week during normal business hours, to discuss patient care and allow response to telephone requests, and to ensure that, in the case of a request submitted pursuant to subdivision three of section forty-nine hundred three of this title or an expedited appeal filed pursuant to subdivision two of section forty-nine hundred four of this title on a twenty-four a day, seven day a week basis;				
(g) Establishment of appropriate policies and procedures to ensure that all applicable state and federal laws to protect the confidentiality of individual medical records is followed;				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
(h) Establish of a requirement that emergency services rendered to an enrollee shall not be subject to prior authorization nor shall reimbursement for such services by denied on retrospective review; provided, however, that such services are medically necessary to stabilize or treat an emergency condition.				
2. Each utilization review agent shall assure adherence to the requirements stated in subdivision one of this section by all contractors, subcontractors, subvendors, agents and employees affiliated by contract or otherwise with such utilization review agent.				
§ 4903. Utilization Review Determinations				
1. Utilization review shall be conducted by:				
(a) Administrative personnel trained in the principles and procedures of intake screening and data collection, provided, however, that administrative personnel shall only perform intake screening, data collection and non-clinical review functions and shall be supervised by a licensed health care professional;				
(b) A health care professional who is appropriately trained in the principles, procedures and standards of such utilization review agent; provided, however, that a health care professional who is not a clinical peer reviewer may not render an adverse determination; and				
(c) A clinical peer reviewer where the review involves an adverse determination.				
2. A utilization review agent shall make a utilization review determination involving health care services which require pre-authorization and provide notice of a determination to the enrollee or enrollee's designee and the enrollee's health care provider by telephone and in writing within **three business days** of receipt of the necessary information.				
3. A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee, which may be satisfied by notice to the enrollee's health care provider, by telephone and in writing within **one business day** or receipt of the necessary information. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date.				
4. A utilization review agent shall make a utilization review determination				

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involving health care services which have been delivered within **thirty days** of receipt of the necessary information.				
5. Notice of an adverse determination made by a utilization review agent shall be in writing and must include:				
(a) The reasons for the determination including the clinical rationale, if any;				
(b) Instructions on how to initiate standard and expedited appeals pursuant to section forty-nine hundred fourteen of this article; and				
(c) Notice of the availability, upon request of the enrollee, or the enrollee's designee, of the clinical review criteria relied upon to make such determination. Such notice shall also specify what, if any additional necessary information must be provided to, or obtained by, the utilization review agent in order to render a decision on the appeal.				
(d) If you are responsible for sending initial adverse determination letters when benefits are denied, reduced or terminated to a Medicaid enrollee, a notice of the enrollee's right to a Fair Hearing in accordance with Section 364-j of the Social Service Law must be attached.				
6. In the event that a utilization review agent renders an adverse determination without attempting to discuss such matter with the enrollee's health care provider who specifically recommended the health care service, procedure or treatment under review, such health care provider shall have the opportunity to request a reconsideration of the adverse determination. Except in cases of retrospective reviews, such reconsideration shall occur within **one business day** of receipt of the request and shall be conducted by the enrollee's health care provider and the clinical peer reviewer making the initial determination or a designated clinical peer reviewer if the original clinical peer reviewer cannot be available. In the event that the adverse determination is upheld after reconsideration, the utilization review agent shall provide notice as required pursuant to subdivision five of this section. Nothing in this section shall preclude the enrollee from initiating an appeal from an adverse determination.				
7. Failure by the utilization review agent to make a determination within the time periods prescribed in this section shall be deemed to be an adverse determination subject to appeal.				
§ 4904. Appeal of Adverse Determinations by Utilization Review Agents				
1. An enrollee, the enrollee's designee and, in connection with retrospective adverse determinations, an enrollee's health care provider, may appeal an adverse determination rendered by a utilization review agent.				

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2. A utilization review agent shall establish an expedited appeal process for appeal of an adverse determination involving:				
(a) Continued or extended health care services, procedures or treatments or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider; or				
(b) An adverse determination in which the health care provider believes an immediate appeal is warranted except any retrospective determination. Such process shall include mechanisms, which facilitate resolution of the appeal including but not limited to the sharing of information from the enrollee's health care provider and the utilization review agent by telephonic means or by facsimile. The utilization review agent shall provide reasonable access to its clinical peer reviewer within **one business day** of receiving notice of the taking of an expedited appeal. Expedited appeals shall be determined within **two business days** of receipt of necessary information to conduct such appeal. Expedited appeals which do not result in a resolution satisfactory to the appealing party may be further appealed through the standard appeal process, or through the external appeal process.				
3. A utilization review agent shall establish a standard appeal process which includes procedures for appeals to be filed in writing or by telephone. A utilization review agent must establish a period of no less than **forty-five days** after receipt of notification by the enrollee of the initial utilization review determination and receipt of all necessary information to file the appeal from said determination. The utilization review agent must provide written acknowledgment of the filing of the appeal to the appealing party within **fifteen days** of such filing and shall make a determination with regard to the appeal within **sixty days** of the receipt of necessary information to conduct the appeal. The utilization review agent shall notify the enrollee, the enrollee's designee and, where appropriate, the enrollee's health care provider, in writing, of the appeal determination within **two business days** of the rendering of such determination. The notice of the appeal determination shall include:				
(a) The reasons for the determination; provided, however, that where the adverse determination is upheld on appeal, the notice shall include the clinical rationale for such determination; and				
(b) A notice of the enrollee's right to an external appeal together with a description, jointly promulgated by the Commissioner and the Superintendent of Insurance as required pursuant to subdivision five of section forty-nine hundred fourteen of this article, of the external appeal process established pursuant to title two of this article and the time				

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frames for such external appeals.				
4. Both expedited and standard appeals shall only be conducted by clinical peer reviewers, provided that such appeal shall be reviewed by a clinical peer reviewer other than the clinical peer reviewer who rendered the adverse determination.				
5. Failure by the utilization review agent to make a determination within the applicable time periods in this section shall be deemed to be a reversal of the utilization review agent's adverse determination.				
§ 4905. Required and Prohibited Practices				
1. (a) Each utilization review agent shall have written procedures for assuring that patient-specific information obtained during the process of utilization review will be:				
(1) Kept confidential in accordance with applicable state and federal laws; and				
(2) Shared only with the insured, the insured's designee, the insured's health care provider and those who are authorized by law to receive such information.				
(b) Summary data shall not be considered confidential if it does not provide information to allow identification of individual patients.				
(c) Any health care professional who makes determination regarding the medical necessity of health care services during the course of utilization review shall be appropriately licensed, registered or certified.				
(d) A utilization review agent shall not, with respect to utilization review activities, permit or provide compensation or anything of value to its employees, agents, or contractors based on:				
(1) A percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment; or				
(2) Any other method that encourages the rendering of an adverse determination.				
(e) If a health care service has been specifically pre-authorized or approved for an insured by a utilization review agent, a utilization review agent shall not pursuant to retrospective review revise or modify the specific standards, criteria or procedures used for the utilization review for procedures, treatment and services delivered to the insured, during the same course of treatment.				
(f) Utilization review shall not be conducted more frequently than is				

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reasonably required to assess whether the health care services under review are medically necessary.				
(g) When making prospective, concurrent and retrospective determinations, utilization review agents shall collect only such information as is necessary to make such determination and shall not routinely require health care providers to numerically code diagnoses or procedures to be considered for certification or routinely request copies of medical records of all patients reviewed. During prospective or concurrent review, copies of medical records shall only be required when necessary to verify that the health care services subject to such review are medically necessary. In such cases, only the necessary or relevant sections of the medical record shall be required. A utilization review agent may request copies of partial or complete medical records retrospectively. This subsection shall not apply to health maintenance organizations licensed pursuant to Article 43 of this chapter or certified pursuant to Article 44 of the Public Health Law.				
(h) In no event shall persons other than health care professionals, medical record technologists or administrative personnel who have received appropriate training obtain information from the health care providers for the use of the utilization review agent.				
(i) The utilization review agent shall not undertake utilization review at the site of the provision of health care services unless the utilization review agent:				
(1) Identifies himself or herself by name and the name of his or her organization, including displaying photographic identification which includes the name of the utilization review agent and clearly identifies the individual as representative of the utilization review agent;				
(2) Whenever possible, schedules review at least **one business day** in advance with the appropriate health care provider;				
(3) If requested by a health care provider, assures that the onsite review shall register with the appropriate contact person, if available, prior to requesting any clinical information or assistance from the health care provider; and				
(4) Obtains consent from the insured or the insured's designee before interviewing the patient's family, or observing any health care service being provided to the insured.				
(5) This subsection shall not apply to health care professionals engaged in providing care or case management or making				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
onsite discharge decisions.				
(j) A utilization review agent shall not base an adverse determination on a refusal to consent to observing any health care service.				
(k) A utilization review agent shall not base an adverse determination on lack of reasonable access to a health care provider's medical or treatment records unless the utilization review agent has provided reasonable notice to the insured, the insured's designee or the insured's health care provider, in which case the insured must be notified, as has complied with all provisions of subsection (i) of this section.				
(l) Neither the utilization review agent nor the entity for which the agent provides utilization review shall take any action with respect to a patient or a health care provider, that is intended to penalize such insured, the insured's designee, or the insured's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination.				
(m) In no event shall an insured, an insured's designee, an insured's health care provider, any other health care provider, or any other person or entity be required to inform or contact the utilization review agent prior to the provision of emergency care, including emergency treatment or emergency admission.				
(n) No contract or agreement between a utilization review agent and a health care provider shall contain any clause purporting to transfer to the health care provider by indemnification or otherwise any liability relating to activities, actions or omissions of the utilization review agent as opposed to the health care provider.				
(o) A health care professional providing health care services to an insured shall be prohibited from serving as the clinical peer reviewer for such insured in connection with the health care services being provided to the insured.				
§ 4910. Right to External Appeal Established				
1. There is hereby established an enrollee's right to an external appeal of a final adverse determination by a health care plan.				
2. An enrollee, the enrollee's designee and, in connection with retrospective adverse determination, an enrollee's health care provider, shall have the right to request an external appeal when:				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
(a) (i) The enrollee has had coverage of a health care service, which would otherwise be a covered benefit under a subscriber contract or governmental health benefit program, denied on appeal in whole or in part, pursuant to title one of this article on the grounds that such health care service is not medically necessary, and				
(ii) The health care plan has rendered a final adverse determination with respect to such health care service or both the plan and the enrollee have jointly agreed to waive any internal appeal; or				
(b) (i) The enrollee has had coverage of a health care service denied on the basis that such service is experimental or investigational, and such denial has been upheld on appeal under title one of this article or both the plan and the enrollee have jointly agreed to waive any internal appeal, and				
(ii) The enrollee's attending physician has certified that the enrollee has a life-threatening or disabling condition or disease (a) for which standard health services or procedures have been ineffective or would be medically inappropriate, or (b) for which there does not exist a more beneficial standard health service or procedure covered by the health care plan, or (c) for which there exists a clinical trial, and				
(iii) The enrollee's attending physician, who must be a licensed, board-certified or board eligible physician qualified to practice in the area of practice appropriate to treat the enrollee's life threatening or disabling condition or disease, must have recommended either (a) a health service of procedure (including a pharmaceutical product within the meaning of subparagraph (B) of paragraph b of subdivision five of section forty-nine hundred of this article) that, based on two documents from the available medical and scientific evidence, is likely to be more beneficial to the enrollee than any covered standard health service or procedure; or (b) a clinical trial for which the enrollee is eligible. Any physician certification provided under this section shall include a statement of the evidence relied upon by the physician in certifying his or her recommendation, and				
(iv)The specific health service or procedure recommended by the attending physician would otherwise be covered under the policy except for the health care plan's determination that the health service or procedure is experimental or investigational.				
3. The health care plan may charge the enrollee a fee of up to fifty dollars per external appeal; provided that, in the event the external appeal agent overturns the final adverse determination of the plan, such fee shall be				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
refunded to the enrollee. Notwithstanding the forgoing, the heath plan shall not require the enrollee to pay any such fee if the enrollee is a recipient of medical assistance or is covered by a policy pursuant to title one-A of article twenty-five of this chapter. The health plan shall not require the enrollee pay any such fee shall pose a hardship to the enrollee as determined by the plan.				
4. An enrollee covered under the Medicare or Medicaid program may appeal the denial of a health care service provided, however, that any determination rendered concerning such denial pursuant to existing federal and state law relating to the Medicare or Medicaid program or pursuant to federal law enacted subsequent to the effective date of this title and providing for all external appeal process for such denials shall be binding on the enrollee and the insurer and shall supersede any determinations rendered pursuant to this title.				
10 NYCRR Part 98				
98-2.9 Responsibilities of health care plans. Health care plans shall be responsible for compliance with all applicable requirements of Article 49 of the Public Health Law and with the following:				
(a) Enrollee requests for experimental or investigations health care services that would otherwise be a covered benefit except for the health care plan's determination that the health care service is experimental or investigational shall be subject to utilization review pursuant to Title 1 of Article 49 of the Public Health Law.				
(b) If a health care plan requires information necessary to conduct a standard internal appeal pursuant to Section 4904 of the Public Health Law, the health care plan shall notify the enrollee and the enrollee's health care provider, in writing, within fifteen (15) days of receipt of the appeal, to identify and request the necessary information. In the event that only a portion of such necessary information is received, the health care plan shall request the missing information, in writing, with five (5) business days of receipt of the partial information. In the case of expedited appeals, the health care plan shall immediately notify the enrollee and the enrollee's health care provider by telephone of facsimile to identify and request the necessary information, followed by written notification. The period of time to make an appeal determination under Section 4904 of the Public Health Law begins upon a health care plan's receipt of necessary information.				
(c) If a health care plan offers two levels of internal appeals, the health care plan may not require the enrollee to exhaust the second level of internal appeal to be eligible for an external appeal.				

Report Requirement	Yes	No	N/A	1. Location of each item, by page number. 2. Ensure that <u>each item</u> is clearly identified.
(d) Notices of final adverse determinations shall comply with all requirements of Article 49 of the Public Health law and will all applicable federal laws and rules.				
(e) Each notice of a final adverse determination of an expedited or standard utilization review appeal under Section 4904 of the Public Health law shall be in writing, dated and include the following:				
(1) A clear statement describing the basis and clinical rationale for the denial as applicable to the enrollee;				
(2) A clear statement that the notice constitutes the final adverse determination;				
(3) The health care plan's contact person and his/her telephone number;				
(4) The enrollee's coverage type;				
(5) The name and full address of the health care plan's utilization review agent;				
(6) The utilization review agent's contact person and his or her telephone number;				
(7) A description of the health care service that was denied, including, as applicable and available, the name of the facility and/or physician proposed to provide the treatment and the developer/manufacturer of the health care service;				
(8) A statement that the enrollee may be eligible an external appeal and the time frame for requesting an appeal;				
(9) For health care plans that offer two levels of internal appeals, a clear statement written in bolded text that the **45 day time frame** for requesting an external appeal begins upon receipt of the final adverse determination of the first level appeal, regardless of whether or not a second level appeal is requested, and that by choosing to request a second level internal appeal, the time may expire for the enrollee to request and external appeal.				
(f) A written notice of final adverse determination concerning an expedited utilization review appeal under section 4904 of the Public Health law shall be transmitted to the enrollee **within 24 hours** of the rendering of such determination.				
(g) If the enrollee and the health care plan have jointly agreed to waive the internal appeal process offered by the health care plan, the information				

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required in subdivision (e) of this section must be provided to the enrollee simultaneously with the letter agreeing to such waiver. The letter agreeing to such waiver and the information required in subdivision (e) of this section must be provided to the enrollee **within 24 hours** of the agreement to waive the health care plan's internal appeal process.				
(h) Health care plans shall facilitate the prompt completion of external appeal requests, including but not limited to the following:				
(1) Health care plans shall provide the enrollee with a copy of the standard description of the external appeal process as developed jointly by the Commissioner and Superintendent, including a form and instructions for requesting an external appeal along with a description of the fee, if any, charged to enrollees for an external appeal, criteria for determining eligibility for a waiver of such fees based on financial hardship, and the process for requesting a waiver of such fees based on financial hardship:				
(i) Simultaneous with a notice of a final adverse determination that a health care service is not medically necessary, including on the grounds that the health care service is experimental or investigational, or;				
(ii) Simultaneous with the written confirmation of agreement between the health care plan and the enrollee to waive the health care plan's internal appeal process, and;				
(iii) Within **three business days** of a request by an enrollee or an enrollee's designee;				
(2) Transmit enrollee medical and treatment records pursuant to an appropriately completed release or releases signed by the enrollee or by a person authorized pursuant to law to consent to health care for the enrollee and, in the case of medical necessity appeals, transmit the clinical standards used to determine medical necessity for health care services with **three business days** of receiving notification regarding the identity and address of the certified external appeal agent to which the subject appeal is assigned, or in the case of an expedited appeal, **with 24 hours** of receiving notification regarding the identity and address of the certified external appeal agent to which the subject appeal is assigned;				

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(3) Provide information requested by the assigned certified external appeal agent as soon as is reasonably possible, but in no event shall the health care plan take longer than **two business days** to provide the requested information. Requests for information relative to expedited appeals must be provided to the certified external appeal agent **within 24 hours**; and				
(4) Provide a form and instructions, developed jointly by the Commissioner and Superintendent, for an enrollee's health care provider to request an external appeal in connection with a retrospective adverse utilization review determination under Section 4904 of the Public Health law, within three business days of a health care provider's request for a copy of the form. For retrospective adverse determinations, health care plans may charge the appealing health care provider up to $50 for each appeal, provided, however, that no fee may be charged to an enrollee for a health care provider's external appeal of a retrospective adverse determination is overturned on external appeal, the full amount of the fee shall be refunded to the appealing health care provider.				
(i) In the event an adverse determination is overturned on external appeal, or in the event that the health care plan reverses a denial which is the subject of external appeal, the health care plan shall provide or arrange to provide the health care service(s) which is the basis of the external appeal to the enrollee. Nothing herein shall be construed to require the health care plan to provide any health care services to an individual who is no longer an enrollee of or insured by that health care plan at the time of an external appeal agent's reversal of a health care plan's utilization review denial.				
(j) Health care plans shall establish the fee, if any, to be charged to enrollees for an external appeal and shall have a methodology to determine the enrollee's eligibility for a waiver of the fee requirement for an external appeal based on financial hardship pursuant to Section 4910.3 of the Public Health Law and Section 4910 (c) of the Insurance Law.				
(k) Nothing in this Subpart shall be construed to relieve the health care plan of financial responsibility for external appeals that have been assigned to a certified external appeal agent. In the case of a health care plan reversing a denial which is the subject of an external appeal after assignment of the appeal to a certified external appeal agent, but prior				

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to assignment of clinical peer reviewer(s), the health care plan shall be assessed an administrative fee as prescribed by the Commissioner and Superintendent.				

D. Please provide the following information:

- Documentation that your organization has been approved by the Secretary of State to do business in New York State.

- A copy of your organization chart demonstrating the position of the utilization review agent, subsidiaries and any parent organization in the corporate structure.

- Copies of your company's determination notices and final adverse determination notices. When preparing the final determination notices, please note:
  - A statement of clinical rationale for an adverse determination must, at a minimum, identify:
    1. The enrollee and the nature of his/her medical condition;
    2. The medical service, treatment or procedure in question; and
    3. The basis or bases on which the utilization review agent determined that the service, treatment or procedure is or was not medically necessary or experimental/investigational, which shall demonstrate that the agent considered enrollee-specific clinical information in its determination.
  - A statement of reasons and clinical rational for adverse determination must be sufficiently specific to enable the enrollee and the enrollee's health care provider to make an informed judgment regarding 1) whether or not to appeal the adverse determination, and 2) the grounds for such an appeal.